PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ PICA ☐☐☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)

1 a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURERS DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO ☐
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY 3 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E By Line) 1. ___ 3. ___ 2. ___ 4. ___		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS- MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For Gov't. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS, (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any False, incomplete or misleading Information may be guilty of a criminal so punishable under low and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary If this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4. 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA, AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claim, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United states Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to tine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 at seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register, Vol. 55 No. 40, Wed Feb. 28, 1996, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S), To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verity information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

OMB No. 1215-0055
Expires: 11/30/2003

Instructions for Completing OWCP 1500 Health Insurance Claim Form For Medical Services Provided Under the Federal EMPLOYEE'S COMPENSATION ACT (FECA) and the Federal BLACK LUNG BENEFITS ACT (FBLBA)

GENERAL INFORMATION: FEDERAL EMPLOYEES COMPENSATION CLAIMANTS

Claims filed under the Federal Employees' Compensation Act (FECA) (5 USC 8101 et seq.) are for employment-related illness or injury. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of disability, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.s), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct subluxation as demonstrated by X-ray to exist.

FEES

The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services to claimants eligible under FECA. OWCP employs a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits call the Department of Labor's Federal Employees, Compensation (FEC) office which services your area.

REPORTS

A medical report which indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined under the Act). The initial report should explain relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

GENERAL INFORMATION: FEDERAL BLACK LUNG BENEFITS ACT (FBLBA) CLAIMANTS

The Federal Black Lung Benefits Act (30 USC 901 et seq.) covers medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the Act. For specific information about reimbursable services, call the Dept. of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

The OWCP is authorized (FECA, 5 USC 8101 et seq; FBLBA 30 USC 901 at seq.) to collect information needed to administrate the FECA and the FBLBA. The information collected is used to identify the eligibility of the claimant for benefits, and determine coverage of services provided. There are no penalties for failure to supply, information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. Failure to supply other information, such as claim number or use of ICD or CPT codes, will delay payment or may result in rejection of the claim because of incomplete information.

SIGNATURE

Your signature in Item 31 indicates your agreement to accept the Government's charge determination on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed).

Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered or were rendered incident to your direct order. Your signature indicates that you understand that any false claims, statements or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

FORM SUBMITTAL

FECA: Send all forms for FECA to the appropriate Federal Employees' Compensation District Office, or to the patient's employing federal agency for forwarding to the correct address.

FBLBA: All forms for services provided under the FBLBA should be returned to the Federal Black Lung Program, P.O. Box 740, Lanham, MD 20706, unless otherwise instructed.

INSTRUCTIONS FOR COMPLETING THE FORM

A brief description of each data element and its applicability to requirements under FECA and FBLBA (Black Lung) are listed below. For additional information contact the U.S. Department of Labor.

Item 1. Check the name of the program being billed.

Item 1a. Enter patient's social security number.

Item 2. Enter the patient's last name, first name, middle initial.

Item 3. Enter the patient's date of birth (MMDDYY).

Item 4. For FECA: leave blank.

For Black Lung: complete only if patient is deceased and this medical cost was paid by a survivor. Enter the name of the survivor to whom medical payment is due.

Item 5. Enter the patient's address (street address, city, state, ZIP Code; telephone number is optional).

Item 6. Leave blank.

Item 7. For FECA: leave blank.
For Black Lung: complete if Item No. 4 was completed. Enter the address of survivor to whom payment is due.

Item 8. Leave blank.

Item 9. Complete "9a-9d" if 11d is "yes". List any potential third party payors other than FECA or Black Lung. This includes other federal programs (Medicaid, Medicare, CHAMPUS, etc.) and any private policy. Include policy number and policy holder's name.

Item 10. For FECA: check the appropriate boxes under 10 a -10c. For Black Lung: not required.

Item 11. For FECA: enter the patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For Black Lung: leave blank.

Item 11a. Leave blank.

Item 11b. For FECA: enter the name of the federal employing agency. For Black Lung: leave blank.

Item 11c. Leave blank.

Item 11d. Check the appropriate box. If "Yes" is checked, list any potential third party payors under Item No. 9.

Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by a witness and relationship to patient indicated.

Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contactural arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, person with power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.

Item 14. For FECA: enter date of injury or first symptom. For Black Lung: not required.

Item 15. For FECA: enter first date of similar illness, injury or symptoms. For Black Lung: not required.

Item 16. For FECA: enter dates (MMDDYY) patient is unable to work in current occupation. For Black Lung: leave blank.

Item 17. and 17a. If this is a referral, enter full name and tax I.D. of referring physician.

Item 18. If services were provided during an inpatient hospital stay, enter the inpatient service days covered.

Item 19. Use for additional information (see Item 24).

Item 20. Must be completed if laboratory service charges are included on the bill. Check "YES" if the services were performed outside the physician's off ice, and enter the amount charged. Enter the name and address of the person/facility providing the service in Item No. 32 with an *. If an independent laboratory is billing, indicate where the sample was taken in 24b.

Item 21. Enter the diagnosis(es) of the conditions(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification, Clinical Modification, 9th revision or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.

Item 22. Leave Blank

Item 23. If a prior authorization number has been assigned provide that number; otherwise leave blank

Item 24. In Column A, enter month, day, and year (MMDDYY) for each service/consultation provided if the "from" and "to" date represent a series of identical services, enter the number of services provided in column "G".

Column B: enter the correct HCFA/OWCP standard "place of service code (see HCFA manual).
Column C: not required

Column D: enter the applicable five digit AMA CPIT (current edition) code and applicable modifier(s) the HCPCS, or the OWCP generic procedure code; enter a brief narrative in columns "J and K".

Column E: enter the diagnostic reference number (1,2,3 or 4, in Item No. 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.

Column F: enter the total charge(s) for each listed service(s). Describe any unusual circumstances in column "J and "K" or attach report to avoid processing delays.

Column G: enter the number of services/units provided for period listed in column "A".
Column "H": Leave blank
Column "I": Enter "YES" if an emergency service.
Column "J" and "K": use for nomenclature or notes.

Item 25. Enter the federal tax I.D. or social security number to which the payment will be assigned.
THIS ITEM MUST BE COMPLETED FOR PAYMENT TO BE PROCESSED.

Item 26. Review notes on FECA, FBLBA and Signature.

Item 27. Enter the total charges from column 24F.

Item 28. If any payment has been made, enter that amount here.

Item 29. Enter the amount due (item 27 less item 28).

Item 30. Enter the balance now due.

Item 31. Signature is required. Print name if not listed in items 32 or 33. For Black Lung: Mechanical reproduction is acceptable.

Item 32. Complete as appropriate: (1) if address is different than that in Item No. 33, (2) If item No. 20 applies, (3) if other circumstances apply.

Item 33. Enter (1) the name and address to which payment is to be made, and (2) your PIN and Group number (if member).
FOR BLACK LUNG in the space following "GRP #", enter your BLACK LUNG SIX-DIGIT FBLBA assigned provider number.
FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE REJECTION OF THE BILL FOR INCOMPLETE/ INACCURATE INFORMATION.

Public Burden Statement

We estimate that it will take an average of ten to fifteen minutes to complete the information required on this form. This includes reviewing of instructions, abstracting information from the patient's records and entering the data unto the form. This time is based on familiarity with standardized coding structures and previous use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of IRM Policy, Department of Labor, Room N-1301, 200 Constitution Avenue, NW, Washington, DC 20210 and to the Office of Management and Budget, Paperwork Reduction Project (1215-0055), Washington, DC 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES